



California State University, San Bernardino
CSUSB ScholarWorks

Electronic Theses, Projects, and Dissertations


Office of Graduate Studies

5-2021

TREATMENT ACCESS FOR DUAL DIAGNOSIS SUBSTANCE USE AND MENTAL HEALTH DISORDERS

Pedro Banuelos

Follow this and additional works at: <https://scholarworks.lib.csusb.edu/etd>

 Part of the Behavioral Medicine Commons, Chicana/o Studies Commons, Clinical and Medical Social Work Commons, Clinical Epidemiology Commons, Clinical Psychology Commons, Cognitive Psychology Commons, Community Health Commons, Community Psychology Commons, Counseling Psychology Commons, Counselor Education Commons, Criminology and Criminal Justice Commons, Diagnosis Commons, Emergency Medicine Commons, Ethnic Studies Commons, Latina/o Studies Commons, Marriage and Family Therapy and Counseling Commons, Mental Disorders Commons, Multicultural Psychology Commons, Other Mental and Social Health Commons, Psychiatric and Mental Health Commons, Psychiatric and Mental Health Nursing Commons, Psychiatry Commons, Psychoanalysis and Psychotherapy Commons, Public Health and Community Nursing Commons, Social Justice Commons, Social Work Commons, Substance Abuse and Addiction Commons, and the Urban Studies and Planning Commons

Recommended Citation

Banuelos, Pedro, "TREATMENT ACCESS FOR DUAL DIAGNOSIS SUBSTANCE USE AND MENTAL HEALTH DISORDERS" (2021). *Electronic Theses, Projects, and Dissertations*. 1177.
<https://scholarworks.lib.csusb.edu/etd/1177>

This Project is brought to you for free and open access by the Office of Graduate Studies at CSUSB ScholarWorks. It has been accepted for inclusion in Electronic Theses, Projects, and Dissertations by an authorized administrator of CSUSB ScholarWorks. For more information, please contact scholarworks@csusb.edu.

TREATMENT ACCESS FOR DUAL DIAGNOSIS SUBSTANCE USE AND
MENTAL HEALTH DISORDERS

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Pedro Bañuelos

May 2021

TREATMENT ACCESS FOR DUAL DIAGNOSIS SUBSTANCE USE AND
MENTAL HEALTH DISORDERS

A Project
Presented to the
Faculty of
California State University,
San Bernardino

by
Pedro Bañuelos
May 2021

Approved by:

Janet Chang, Faculty Supervisor, Social Work

Armando Barragán, M.S.W. Research Coordinator

© 2021 Pedro Bañuelos

ABSTRACT

In 2018, of 1.3 million Latinx adults in the United States facing concurrent issues with substance use disorders (SUD) and mental health disorders (MHD) 93% remained untreated for either diagnosis. This is concerning since Substance Abuse and Mental Health Services Administration (SAMHSA) data reveals that this population is at greater risk for suicidal thoughts, plans, and attempts. They also face structural barriers such as employment, housing, legal involvement, and insurability that further impede access to treatment.

This study's purpose was to examine barriers to accessing treatment for Latinx populations confronting co-occurring SUDs and MHDs. This study used a qualitative design and data were collected from telephone or zoom interviews with five Latinxs who identified themselves as dually diagnosed (DD) within the Inland Empire of Southern California.

This study found that participants reported stigma from the community and cultural forces as a major barrier to treatment. The study revealed that participants viewed structural factors such as being uninsured, being incarcerated, having transportation difficulties, and having work scheduling difficulties as barriers to treatment. This study also indicated difficulties in diagnosing a DD, which often led to an inability to consider how one diagnosis might impact another and ultimately delayed actions to treat a DD.

It is recommended that social workers ensure understanding of unique DD experiences so they can proactively assess for substance use in early

adolescence. To address structural barriers, this study recommends universal access to medical coverage for all individuals, which ultimately foster advanced preventative interventions for DD individuals.

DEDICATION

Dedicado a mis padres por todo lo que me han enseñado. Todo esto no sería posible sin ellos. Gracias a todos los que me ayudaron a lograr esto.

A special thanks to my brother and sister for helping me to see from their points of view and for always being there for me. To my dear friends: Michelle, Abraham, Marmar, and so many others I want to thank for helping me to keep going and for being there to hear me out.

I would also like to thank Project Rebound for their guidance and support throughout this endeavor.

TABLE OF CONTENTS

ABSTRACT	iii
CHAPTER ONE: INTRODUCTION	1
Problem Formulation.....	1
Purpose of Study	3
Significance of Study to Social Work	3
CHAPTER TWO: LITERATURE REVIEW.....	5
Introduction	5
Psycho-social Implications	5
Structural Implications.....	8
Theories Guiding Conceptualization: Sociocultural and Systems Theory	11
Summary	12
CHAPTER THREE: METHODS	13
Introduction	13
Study Design	13
Sampling.....	15
Data Collection and Instruments.....	15
Procedures	16
Protection of Human Subjects	17
Data Analysis.....	18
Summary	18
CHAPTER FOUR: RESULTS.....	19
Introduction	19

Findings	19
Demographics	19
Initial Onset of Mental Health Disorders and Substance Use Disorders.....	20
Historical Conceptualization of Mental Health Disorders and Substance Use Disorders	21
Treatment of Mental Health Disorders and Substance Use Disorders.....	23
Barriers and Facilitators to Treatment	24
Management	25
Perceptions towards Treatment	26
Role of Support	28
Summary	29
CHAPTER FIVE: DISCUSSION	30
Introduction	30
Discussion	30
Stigma.....	30
Self-medication	31
Identification and Prevention.....	32
Structural Considerations.....	34
Support as Empowerment.....	35
Limitations.....	36
Recommendations for Practice, Policy, and Research	36
Conclusion	38
APPENDIX A: DEMOGRAPHIC SURVEY	39

APPENDIX B: INTERVIEW GUIDE	41
APPENDIX C: INFORMED CONSENT	44
APPENDIX D: RESEARCH FLIER.....	49
APPENDIX E: DEBRIEFING STATEMENT.....	51
APPENDIX F: INSTITUTIONAL REVIEW BOARD APPROVAL	55
REFERENCES	58

CHAPTER ONE

INTRODUCTION

Problem Formulation

As Social Workers enter the professional field they will work with a multitude of client populations, each of which having varying and competing needs. The population of focus here will be dual-diagnosed (DD) Black and Latinx individuals with mental health diagnoses (MHD) and substance use disorders (SUD). These comorbidities in addition to racial historical trauma and systematic deprivation for minority populations may complicate treatment approaches. Clinicians must be aware of the special implications that a DD entails for this population. This population's unique social position warrants an exploration into addressing the psycho-social factors that are applicable, with a special emphasis on institutional policies such as health care access, legislation, and criminal justice.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2018 there were 1.1 million Black adults who had a SUD with a co-occurring mental illness, of which 91% received no treatment for either diagnosis (SAMHSA, 2018a). In that same year 1.3 million Latino adults had a SUD with a co-occurring mental illness where 93% received no treatment for either diagnosis (SAMHSA, 2018b). For both populations SUD with co-occurring MHD is associated with higher rates of suicidal thoughts, plans and

attempts (SAMHSA, 2018a; SAMSA, 2018b). This accounts for about 2.4 million people who have specific needs that must be met concurrently.

Lo and Cheng (2011) discuss the disparities for minority groups within healthcare, where often services that are critical for maintaining well-being and prevention are not provided, which result in higher rates of mortality from substance treatment related conditions through accidents, relapse and violence when compared to non-Latinx White populations. The authors explore factors that increase rates of mortality such as infrequent access to treatment that may arise from cost of care, lack of insurance coverage, discrimination, mistrust and/or services that do not provide quality treatment. This study focused on the type of treatment that individuals accessed, where specialty treatment was defined as consultation with a substance trained professional (operationalized as at least several counseling sessions with a psychiatrist, social worker, psychologist or similarly trained professional and medication management services). Non-specialty treatment was defined as consultation with a health care provider not specifically trained in substance or behavioral interventions (Lo & Cheng, 2011).

The Black population was less likely to report accessing specialty treatment compared to non-Latinx White populations (Lo & Cheng, 2011). At the same time, the Black population and Latinx population were more likely to access non-specialty treatment (Lo & Cheng, 2011). The implications of this are

important to consider since so few Black and Latino individuals, as noted by SAMHSA data, seek treatment to begin with.

Purpose of Study

The purpose of this study was geared toward assessing the quality of treatment services for dual diagnosed Black and Latinx populations in order to understand what treatment areas could be improved upon. To contextualize the variability of services, within an analysis of programs meant to treat the DD population across the United States, only 18% of addiction focused settings and 9% of mental health focused settings were able to provide adequate DD specific care (McGovern et al., 2014). By studying the efficacy of services, as a means of finding methods to improve them, it is possible to cultivate greater participation and trust within treatment programs.

This research was conducted through individual interviews that assessed community perceptions and barriers to available services. This was necessary in order to calibrate the study measures to the specific Inland Empire region. By establishing a clear background of past and/or current treatment access by participants, there was a better understanding of the community's perceptions and needs.

Significance of Study to Social Work

In order to understand how to rehabilitate and reconstitute communities, research into treatment disparities was necessary. Robbins et al. (2011) found

that in an analysis of Brief Strategic Family Therapy versus Community-based Outpatient programs for SUD, Black adolescents had lower rates of engagement and retention compared to peers across treatment type. Alegria et al. (2011) notes that disparities in SUD treatment access may be rooted in negative attitudes towards help-seeking within Black and Latinx communities compared to non-Latinx White communities. The findings of this research sought to establish clarity in methods to treat minority communities facing DD comorbidities. Given the previous research trend it was important to specifically interview the Inland Empire population on its perceptions to treatment programs.

By engaging in the evaluation phase of the Generalist Intervention Model this study has been able to get a sense of the Inland Empire's ability to address and treat DD individuals. By exploring this topic, this research aimed to pioneer a revitalized approach to DD treatment outcomes for Black and Latinx populations. This research is motivated to create a wider array of treatment approaches that will enable greater access to rehabilitation. This research could be beneficial to social work students who are in the process of developing their clinical skills. This research will also allow for discussion and the development of a necessary awareness of the multimodal approaches needed to holistically treat Black and Latinx populations. In order to do so, the guiding question was: What are the barriers to accessing treatment for Black and Latinx populations confronting SUDs with co-occurring MHD and systemic issues?

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter consists of an investigation of the challenges to reaching adequate treatment and the issues that develop during this process. The research is divided into sections where the first portion assessed the psycho-social implications of legislature and in-practice procedures. This is followed with the section on structural implications of dually diagnosed experiences. The final subsection discusses the applicability of sociocultural theory and systems theory for DD Black and Latinx populations.

Psycho-social Implications

Within California after the enactment of Proposition 36 in 2000, a measure to redirect individuals with substance related offense away from incarceration and into community-based treatments, a comparison between DD individuals and their singularly diagnosed substance using counterparts showed an increased recidivism for DD individuals who had severe mental health diagnoses (Jaffe et al., 2012). These findings also reported an increased rate of incarceration, unemployment, unsuccessful substance treatment and rearrests for individuals who were DD (Jaffe et al., 2012). Without taking Prop 36 into account, the likelihood of individuals who were DD to initiate and engage in treatment was less likely for men with schizophrenia and individuals who were actively drug dependent with recent arrests (Brown et al., 2011). Although positive connection

and support from family may have aided in initiation and engagement of substance treatment; severe symptoms, chaotic living circumstances, poor self-care, poor life functioning, poor symptom management and legal obligations impacted the ability to seek and engage in treatment (Brown et al., 2011). There is a need to consider the structural forces (legal obligations, lack of housing, homelessness, transportation issues and time/schedule requirements) that drive this population away from service initiation and engagement (Brown et al., 2011). The psycho-social impact that these inter-dynamic issues illustrate is a highly complex lived experience that necessitates the ability to actively manage individuals' symptomology and behavioral approaches concurrently. Otherwise, the amount of strain that this interplay has on individuals may very well exacerbate already present issues; thereby impacting their ability to enroll in treatment.

Wu and Hser (2011) researched Prop 36 treatment providers and found that during the initial year only 53% of the workforce was certified as substance use counselors, additionally of that group only 56% of the certified counselors (meaning roughly one-fourth of total staff) had a master's degree or higher education. The authors note that as funding increased to enrich workforce staff, the amount of staff that was not certified or that held higher education degrees remained similar. These types of facilities were the kind that were available to individuals seeking to initiate services to manage their symptoms. With this having been the case, the question of whether or not ethical practices were used

arises. This must be explored since the previously mentioned psycho-social burdens can lead to an increased difficulty for retention or disengagement.

In a review of 11 guidelines for treating co-occurring substances and mental illnesses, Perron et al. (2010) found that all guidelines were intended to be used by medical professionals while of those, only 8 were meant to be used by behavioral health professionals. Of these 11 guidelines only 2 provided in-depth treatment protocols while the others remained vague and open for interpretations by facilities (Perron et al., 2010). Perron et al. (2010) specifically drew attention to the differences between American Psychiatric Association (APA) guidelines for schizophrenia with dual substance use and those for bipolar disorder, which lacked protocols for co-occurring substance treatment even though there are higher prevalences for co-occurring substance use for bipolar disorders. When facilities come across these types of guidelines, which lack necessary specificity to adequately treat DD populations, there is a danger of malfeasance in their application.

Although there is research supporting the need for dual diagnoses treatment integration, the field is still in need of perfecting techniques to reach larger populations. The role of social workers is to expand the ground leveled practice to incorporate a more cohesive treatment for DD populations. Further efforts to do this will likely entail efforts on shifting ideologies surrounding substance use policies within legislature and the larger social world. Going further, structural components such as housing, employment, transportation, and

similar needs will have to be coordinated as part of a holistic dual diagnoses treatment, especially for systems impacted individuals.

Structural Implications

Veterans with a DD of Post-Traumatic Stress Disorder (PTSD) and SUD tend to self-medication through illicit substances to lessen the symptoms of PTSD, which exacerbated their daily functioning by debilitating psycho-social skills (Owens et al., 2014). Owens et al. (2014) found that veteran groups with DD (PTSD and SUD) and those with only PTSD and no SUD had higher rates of depression and avoidant attachments to their peers when compared to groups diagnosed with only SUD and no PTSD. This suggests that the MHD within DD groups may be an indication of higher risk to psycho-social functioning issues, when compared to groups that expressed a singular SUD diagnosis without MHDs. It is important to explore the interactional effect of multiple diagnoses to better clinicians' understandings of treatment approaches, as not doing so would result in deteriorated psycho-social functioning, specifically in the case of accessing treatment. In the case of DD alcohol use with anxiety, use of Cognitive Behavioral Therapy (CBT) to simultaneously treat comorbidities was shown to reduce alcohol dependencies while having no observable effect on other substances when comparing to individuals receiving services for a singular diagnoses of SUD or anxiety (Wolitzky-Taylor et al., 2018). This finding suggests that addressing the MHD comorbidity while simultaneously addressing the SUD through psychotherapeutic approaches could have greater impacts in treatment

methods overall, since the accompanying MHD comorbidity may be driving SUD behaviors (Wolitzky-Taylor et. al, 2018).

Given the nature of clinical work and the urgency needed to diagnose, clinicians may elect to focus on SUDs singularly as they may be more apparent. This could cause negative consequences for clients since there are nuances within DD MHD and SUD that go beyond the needs of SUD alone. For instance, Minkoff (2019) discusses the propensity of clinicians to diagnose individuals in substance related crises with substance-induced disorders instead of properly investigating client psychiatric histories for information that could lead to more appropriate care/treatment. Minkoff (2019) asserts the possibility of gathering a more complete background through analyzing mental states within periods of sobriety in addition to collateral information so that clinicians may accurately assess the contexts that triggered the substance related crisis. Temporarily stabilizing SUDs while leaving obscure MHDs untreated, may lead to cyclical patterns of relapse and continued SUD, which may only worsen over time.

Mericle et al. (2012) notes that individuals with DD are more likely to have poorer health, face housing and employment difficulties, and have histories of suicide attempts. The consequences of improperly diagnosing DD may result in the loss of social capital within communities. Given the prevalence of substance use and its effects on marginal social spaces, SUD is a major issue that robs communities of potential through the loss of unrealized potential from individual members. This means that in order to holistically address DD within this

structural setting there must be a re-integrative approach to treatment. Some aspects of this community re-integration approach are present in an analysis of SUD on homeless individuals (where homelessness is a structural comorbidity that affects psychological functioning). Carver et al. (2020) found that the manner in which treatment interventions were provided made the biggest impact in increasing the homeless' likelihood of substance abstinence. Homeless individuals were able to receive transitional services that ensured their likelihood to retain homes with basic training in home skills and substance avoidance within a hospitable and empathetic environment (Carver et. al, 2020).

In a multiracial and ethnic study that assessed Individuals' co-occurring disorders of SUD and MHD, Mericle et al. (2012) found that despite White populations having a higher occurrence of DD SUD and MHD; Black, Latino and Asian populations with DD SUD and MHD were more likely to be unemployed. The authors also noted that Black populations were underrepresented in access to psychiatric hospitalization, noting potential differences in access to care or in help seeking behaviors as potential explanations for this. Compared to peers who only had either SUD or MHD, those experiencing DD tend to be more vulnerable to psychosocial impairments across race and ethnicity (Mericle et al., 2012). Additionally, most respondents with DD reported that they experienced symptoms of MHD prior to developing symptoms of SUD, which points toward the need for SUD prevention as an important treatment objective when individuals are first treated for early onset MHDs (Mericle et al., 2012).

In order to understand the DD population's barriers to treatment more comprehensively, an intersectional analysis is necessary to dissect the structural implications of accessing treatment. For example, looking more closely at the disproportionality of unemployment for minorities with DD should shed light on structural inequalities, specifically tied to racial and ethnic backgrounds.

Theories Guiding Conceptualization: Sociocultural and Systems Theory

Alegria et al. (2011) proposes a sociocultural framework of health service disparities through six levels of analysis on 1) federal and economic health care policies and regulations, 2) operations of the health care system and provider organization, 3) provider level factors, 4) social and economic forces on environment, 5) the community system, and 6) client leveled factors in order to understand the creation and maintenance of health service disparities. This adaptation of Vygotsky's Sociocultural theory describes a similar functionality of cultural influence on an individuals' functioning within a system, where through engagement within varying levels of structural components ranging from the individual to the community to the economic and political levels an individual learns how to access health care.

Additionally, Systems Theory could be beneficial to provide a schema of interrelating mechanisms that would illustrate health care functioning. A special emphasis on the overarching system, subsystems, their relationships and ascribed roles, inputs and outputs, as well as feedback and interface analysis

could help to determine where the system is lacking engagement (Zastrow & Kirst-Ashman, (2016, 2019).

Summary

There is a need to further study treatment disparities within DD Black and Latino populations due to lacking research in treatment outcomes. The psychosocial barriers in combination with structural barriers further obfuscate the issue. A detailed examination of various sublevels within the sociocultural framework serves as a foundation to further explore and understand the system in which these populations exist. By establishing a consolidated understanding of these phenomena and reflecting upon it through community input, the next steps in systemic change will become clearer.

CHAPTER THREE

METHODS

Introduction

This research explored the perspectives of individuals in seeking and accessing treatment for DD SUD and MHD. The methods of this analysis are described in this section. Further discussion on the study design, sampling, data collection and instruments, procedures, protection of human subjects, and data analysis follows.

Study Design

The purpose of this study was to explore the factors that affect individual participation in seeking and accessing treatment for DD SUDs and MHDs disorders for the Black and Latino populations within the Inland Empire of Southern California. This was done through the use of qualitative interviews with participants. Qualitative interviews were chosen in order to allow individuals the chance to explore the factors that have impacted their access while also assessing the feelings towards seeking and accessing treatment. Through collecting the direct experiences of individuals who are missing from the data, the data collection aided in establishing a necessary foundation of information for the issue of low treatment access and participation for this population. Through detailing the direct experiences of individuals, the discourse became client

centered. This allowed for emphasis on the needs and opinions of individuals as the guiding framework for future work in addressing treatment gaps.

A limitation to this research was COVID-19's effects on information gathering. Individuals may have been less inclined to participate in interviews with researchers via technological methods due to the lack of human interaction and discomfort surrounding privacy. Individuals may have been opposed to online or telephonic interviews with strangers in general. Additionally, locating participants who fit study criteria proved difficult since individuals may not have been formally diagnosed. Individuals may not have been aware of applicable diagnoses that would have made them applicable for study. Participants may have felt stigmatized and preferred not to participate in research. There may also have been cultural factors, historical trauma, doubt, or suspicion that inhibited participation within the research process. In addition, there will be a limitation on how generalizable the data is to the national population since it was focused on a small participant pool and specific regional area.

A strength to this research was the ability to contextualize the Inland Empire's experiences within the issue of treatment access. With this specific knowledge it may be possible to better develop methods of attracting Black and Latinx individuals towards seeking and participating in treatment. In addition to these benefits, the participants' insights may be applied to the development of treatment approaches and interventions. Further research can be developed to expand the scope of treatment in the future.

Sampling

The research sample was gathered through purposive and snowball sampling and consisted of 5 participants who slightly varied in gender identity and identified as Latinx and were formally or informally diagnosed in having DD SUDs and MHDs. No individuals that identified as Black participated. Participants were solicited to contact the researcher if they were interested in participating through flyers (Appendix D) indicating the type of research to be conducted with a brief description of qualifications and time needed to participate.

Data Collection and Instruments

IRB approval was granted to conduct qualitative interviews that were audio-recorded from telephonic or Zoom videoconferencing technologies. Interviews began with informed consent (Appendix C) and an explanation of the purpose for the research. The researcher gathered demographic data through a demographic survey (Appendix A) focused on racial/ethnic identification, gender identification, age, educational level, geographical background, medical insurance coverage, annual income, and applicable diagnoses.

Each interview followed the interview guide (Appendix B) that was available in English and Spanish. The guide was composed of open-ended questions that focused on eliciting participants' thoughts and feelings of their personal experiences. The areas of discussion were individual feelings in navigating community spaces as a DD individual, family and cultural/community perceptions of DD experiences and treatment options, and individual or familial

support in seeking treatment or other types of assistance. The researcher also probed further if certain answers were unclear or would benefit from further explanation.

Procedures

The researcher created a flyer advertising the project with a \$10 gift card incentive to participate, a brief description of the type of study and the demographic of interest with contact information of the researcher. These flyers were distributed by Project Rebound at California State University, San Bernardino that had accepted partnership after IRB approval. The researcher coordinated around the schedules of participants in order to allow greater access to interview times. Participants were able to decide what method they preferred to use, telephone or video call, when signing up. Interviews were done in a 1:1 format. The researcher e-mailed all confidentiality and informed consent documents to participants in advance of interviews. If email was not a good method of receiving this documentation, the researcher acquired verbal consent to participate in the study after reviewing informed consent documents with participants.

During interviews, the researcher reviewed the informed consent document and discussed confidentiality to ensure participants were aware of the information and protocols. The researcher reminded participants that they had the right to disclose the amount of information they felt comfortable disclosing and that they had the freedom to resign from the study at any point in time. The

researcher took additional notes as participants spoke in order to create a visual flow chart of ideas and develop content connections. If participants became upset or distressed during the interview, the researcher paused to assess their wellbeing and de-escalate with breathing exercises or de-briefing. Once participants were stable the researcher would ask if they wished to continue and remind them that they were not obligated to continue. Once interviews were completed the researcher took the time to assess the participant's emotional state and give debriefing statements (Appendix E). The researcher also provided local resources in case the participant was interested in seeking support or future services. The researcher thanked the participant for their time and participation.

Protection of Human Subjects

Participants were given pseudonyms upon signing up for the study. After which the researcher only referred to participants by their pseudonyms in all forms of communication. Actual names were recorded with pseudonyms in a physical document that was locked within a case folder. Digital audio recordings were kept in a password protected flash drive that was locked with physical logs. Recordings were transcribed with researcher created code names for further identity protection. Once information was processed it was discussed in broad categories/charts in order to make re-identification of participants difficult. These materials will be destroyed 3 years after completion of the study.

Data Analysis

Demographics variables were analyzed using descriptive statistics. The interview data was first transcribed chronologically as presented in interviews. Then the data was analyzed by major and minor themes through a content analysis process. Individual code names were be created for this transcription process in order to further remove identifying features. The transcripts included non-verbal sounds and body language/movements if any were relevant to dialogue.

Summary

The best approach to understanding perspectives of individuals in seeking and accessing treatment for dual diagnoses SUDs and MHDs was through qualitative interviews. Information provided by participants aided to delineate the work needed for future research and treatment development.

CHAPTER FOUR

RESULTS

Introduction

This chapter will cover participant demographics and applicable personal backgrounds. A discussion of major themes involving first use/onset, individual conceptualization on MHD intersecting with SUD, experiences in treatment access and use, motivations and barriers toward treatment, DD management techniques, personal and cultural opinions toward treatment, as well as exploring support mechanisms.

Findings

Demographics

A total of 5 participants who volunteered for this study met criteria for research participation. This sample was compromised of 4 self-identified Males (80%) and 1 self-identified Female (20%). All participants identified as Latinx or a similar subgroup (such as Chicano, Hispanic, Mexican). No participants identified as Black or African American.

The median age of participants was 40 years old, with 25 years being the youngest and 44 years old being the oldest. Two participants ranged from 25-35 years old. Three participants ranged from 36-45 years old. Participant educational levels were broad with two participants having completed high school or a high school equivalent, one participant currently in college leveled

coursework, and two participants with bachelor's leveled degrees. All participants lived within the Inland Empire for the last 10 years at time of study. Two participants had medical insurance through Medi-Cal, two participants had medical insurance coverage through their employment, and one participant had no medical insurance. Average annual income was \$32,000, ranging from \$12,000 to \$55,000 annually.

All participants had a varied history of substance use with accompanying mental health diagnosis, or characterization of sufficient symptomologies to warrant identification by individuals. Substance use was classified as problematic to functioning in order for it to be relevant to study. Substance use varied from alcohol to stimulants as well as opioids with 80% of individuals (4 participants) reporting often using more than one type of substance. Two of the participants experienced neurodevelopmental diagnoses, specifically ADHD and Specified Learning Disorder. One participant experienced anxiety disorder. The two remaining participants experienced Schizophrenia spectrum disorders, specifically Schizoaffective bipolar type and Schizoaffective depressive type.

Initial Onset of Mental Health Disorders and Substance Use Disorders

The average age of substance use was 13.6 years with sixty percent (3) individuals reporting alcohol as initial substance. On average the participants reported experiencing their first MHD symptoms at 16.2 years old. Participants with neurodevelopmental and anxiety disorders experienced early onset of MHD and SUD when compared to schizophrenic spectrum disorder.

Neurodevelopmental and anxiety prone individuals experienced MHD at younger ages from ranging from 8 to 13 years old. This group reported initial substance use ranging from 10 to 13 years old. Schizophrenic spectrum participants experienced MHD later in life, with MHD presenting at age 19 and 28. Of this group, participants began using substances at 22 and 10, respectively. Eighty percent (4 participants) reported first having a MHD symptom before initiating substance use.

Historical Conceptualization of Mental Health Disorders and Substance Use Disorders

Respondents reported a common theme of environmental stressors within a range of social settings as heavily influencing their substance initiation. For the three participants (60%) with neurodevelopmental and anxiety disorders, environmental stressors were predominately school based where academic performance and social interactions, respectively, caused dysphoria. Two participants (40%) with schizophrenic spectrum disorders experienced family-based stressors that initiated substance use. Participant 1 explained their first substance use

Started out smoking pot, thought, it was fun. There was, you know, uh, from pot it turned to... sniffing paint, it's just, the experience for me, its just, I guess it made me, uh, like my... I b- I basically, it just made me feel numb to where I just... Like, how do you say... suppress my feelings while

I was still inside? (Participant 1, personal communication, January 14, 2021).

Additionally, two (40%) participants of each group experienced grief from the loss of a significant family member which caused more serious substance use frequency as compared to previous self-reported use.

When participants were asked if they felt there were any connection between MHD and SUD, three participants (60%) in the neurodevelopmental and anxiety group reported that dysphoric emotions from MHD led into substance use. For example, Participant 3 reported

When all of my other classmates were acing their tests and stuff that, I guess it just kinda made me want to just go hang out with the people, you know, that there were also messing up and those people, those people were doing like drugs and alcohol (Participant 3, personal communication, February 18, 2021).

Two participants (40%) with schizophrenic spectrum disorders reported that MHD symptoms had always been present but that substances made them worse.

When asked about a possible connection between MHD and SUD Participant 4 stated that the MHD was already present but that substances exacerbated it with, "I really do feel like it got worse, but it didn't, it wasn't determinate- It didn't determine my mental health" (Participant 4, personal communication, February 9, 2021).

Treatment of Mental Health Disorders and Substance Use Disorders

In terms of having received treatment, 40% (2 participants) received no treatment while the remaining 60% (3 participants) received a type of DD treatment through in-patient services and/or outpatient services. Two participants (40%) that utilized outpatient DD services who also utilized peer-support groups, prior to COVID-19's emergence. Participant 4 expressed how crucial this support was by stating

Also especially group therapy where others are experiencing the same problem that you have, that way you can relate to others, and you feel like you're not the only one, you know, like there's other people going through this too (Participant 4, personal communication, February 9, 2021).

At time of study all participants reported maintenance of symptom management with continuation of treatment, if enrolled in treatment. Those that accessed treatment reported overall pleasant feelings towards care and providers. One respondent, however, had an instance of negligent care characterized by rapid and unprecipitated changes to treatment that resulted in serious relapse prior to being on a stabilized treatment. Participant 1 reported,

I was with one doctor and we had got the medications down, I thought that I was doing really good. And then, but he retired. then the other doctor came in and she, from the minute I met her, she was just like, 'Oh, I know this. I've been doing this for this many years. And you're on too much of this and you're on too much of that.' And she basically like took

medications away, started prescribing new ones. (Participant 1, personal communication, January 14, 2021).

Barriers and Facilitators to Treatment

Respondents reported barriers to treatment as: structural limitations, such as not having insurance and concern over out-of-pocket costs; a need to work in order to provide for family; feelings of being able to control drug dependencies through a desire to combat SUD independently; and cultural stigma in accessing treatment. Participant 2 summarized these conflicting issues with, “providing for my family, um, having to be, um, placed in a residential setting, um, being away from my family, um, you know, the job restraints” (Participant 2, personal communication, January 26, 2021). Participant 5 echoes these sentiments in explaining their hesitancy for treatment as an uninsured person as “mostly an economical issue than the desire to seek help.” (Participant 5, personal communication, February 9, 2021). Additionally, participant 5 reported their family’s distrust “when it comes to medication for treating mental health and mental illness.” continuing with, “I think everything to the point of psychiatry is okay.” (Participant 5, personal communication, February 9, 2021).

Participants stated motivations for seeking treatment to be: fear of losing family and family support system, having family support in trying to access care as well as concern for wellbeing, and a desire for self-understanding of symptoms and their triggers. Participant 3 stated a motivation to change was rooted in fear of losing their family

Just losing my family. Like, uh, the fear of like, my family not, is longer, no longer being there. Losing my kids, not seeing my kids anymore and just, I don't know just letting my parents down. (Participant 3, personal communication, February 18, 2021).

For participant 4 structural barriers actually encouraged treatment as they stated,

I ended up homeless for a while and, um, I was, uh, like I said, I was misunderstood. I, I slept in parks, I slept, uh, in the street sometimes and not knowing where I was gonna go. And that's why most of the time I had checked myself into one, a hospital so that they can give me hospitality that I needed too. I was alone. I was on the streets. (Participant 4, personal communication, February 9, 2021).

Management

Respondents reported varied methods of managing history of DD symptomologies from the use of prescription medicines to aid dependence, use of support groups, support from family, and creating changes in behavioral patterns such as: developing self-regulation skills; avoiding triggers; finding better methods of coping; and healthy dieting with exercise, even when not enrolled in treatment. Respondent 3 cited their efforts at keeping away, “from anybody that was like a trigger. Being around anybody that I knew that gets high or had anything to get high with, it just made that itch come right back” (Participant 3, personal communication, February 18, 2021). Participants reported feelings of

pride and accomplishment with personal development in managing DD. In reflecting upon this, Participant 5 stated

It was definitely a sense of, I wanna say, almost of pride, you know, knowing that what once used to be a source of so much stress and discomfort now, now is only a small shadow of what it used to be”

(Participant 5, personal communication, February 9, 2021).

Perceptions towards Treatment

When asked about their opinions to seeking DD treatment 60% of the participants (3 participants) reported not having considered the specific type of treatment. Participant 1 stated, “I never thought about that. I've never really, honestly, I never been like, presented with anything like that.” (Participant 1, personal communication, January 14, 2021). Some feelings of reluctance surfaced for participants who felt they could manage on their own as stated by Participant 3,

It was the fact, just thinking that I was okay. You know, that, that I had control of the drugs, not, not the other way around... every time that I would get out, like I would slowly start using again, like slowly here and there. And I would go, ‘Well, you know, I, I got it under control. I got it under control.’ And then by the time that I realized I was already in jail.

(Participant 3, personal communication, February 18, 2021).

Upon reflection, these participants stated that if DD treatment approaches were available during their initial symptomologies, they might consider them as an

option to take. The remaining 40% (2 participants) encouraged seeking a DD treatment, stating they would and did seek such treatment. Participant 4 reported, “I was the type of person that always, you know, was able to seek medical attention.” (Participant 4, personal communication, February 9, 2021).

As a whole, family perceptions towards seeking treatment were good but there were some feelings of doubt of respondent's ability to get treatment, mistrust in medication use, and fears associated with enrolling in treatment. On a cultural level, participants reported stigma from their community, shame from family members, the community's inability to understand, and overall judgment against DD individuals. Participant 4 described their community as,

They're just very judgmental. And, um, that's where their bottom-line lays, you know, I don't think that there's probably any people out there that give you that type of— or tries to even give you that type of understanding.

(Participant 4, personal communication, February 9, 2021).

Participant 3 reported similar accounts about their father, “he probably would have been ashamed” and their close peer group, “my homies, if they would have known they probably would have been making fun of me, you know, cracking jokes and stuff” (Participant 3, personal communication, February 18, 2021).

Participant 5 noted that culturally some substances, such as alcohol, are normalized and even accepted whereas MHD are not. Participant 5 explained

I think culturally substance abuse, given, depending on the substance of course, it doesn't carry as much of a social stigma, even not compared to

mental illness. I think socially there's more weight on mental illness than, you know, like in this case, alcohol consumption. So, I don't see it being a topic of concern just to seek a dual diagnosis in this case. (Participant 5, personal communication, February 9, 2021).

Role of Support

Most respondents (60%) cited family support throughout substance use and dependency stating that parents or siblings had a major influence in always being present. Participant 2 emphasized the importance of this support with

My parents were, my parents have never left my side. Never ever left my side. Um, and that, that, that's the reason I think I'm where I am. Where I'm at today because of them. Um, they didn't, they didn't, they didn't say, you know what, *washes-hands-off gesture* fix 'em, you know, they didn't, they didn't have that mindset. You know, they didn't put me in a treatment center and say, 'look, we're just leaving you here. Fend for yourself.' Um, they were supportive of me throughout the whole, throughout the whole process, um, you know, going to prison, which my addiction eventually led me to, um. They stayed, they remained supportive as well (Participant 2, personal communication, January 26, 2021).

Participant 3 experienced the same level of support

Even my dad as like, he was the last one to find out that I had a drug problem because I was scared to tell him. He didn't find out 'til like the last time that I got arrested. And I kind of just, as they were taking me in, I kind

of just told him like, ‘Hey man, I’m messing up, I have a drug problem. This and that.’ It looked like it hurt him, but I didn’t get the reaction that I expected from him. You know, I thought I was going to get anger and shame and maybe even get— maybe even lose like any support that he had and he was helping me with, you know, but on the contrary, you know, like I saw a softer side from him, you know, he kinda just stayed there. You know, even when I was in prison, he would, he would give me like good letters, you know, and just telling me, like ‘Oh, you know, hope you’re doing good’ tell me how he couldn’t wait for me to get out and like, how he was fixing a truck for me to use to start working as soon as I got out, like, you know, trying to get me back on my feet.” (Participant 3, personal communication, February 18, 2021).

Other participants (40%) stated that family would attempt to support them but be unable to completely understand the circumstances.

Summary

This chapter has reviewed participant demographics and their backgrounds to contextualize the findings. Topics of interest were circumstances around initial substance use and MHD symptoms, personal understandings of DD, treatment experiences, motivations and barriers in treatment access, individual management skills, cultural perceptions of treatment, and supports available to individuals with DD.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter will discuss the major findings from chapter 4. Following this will be the limitations of this study and recommendations for the social work profession. Recommendations are aimed at addressing social work field practice, policy advocacy, and academic research. The chapter closes with the implications of this research and a summary.

Discussion

Stigma

The first major findings center on stigma from the community, where participants noted that friends and cultural forces would look down upon them or view them negatively, and how these stigmatizing perceptions made treatment less preferable. Participants' more immediate family seemed to range in support for treatment from skeptical to accepting. This shows that closer family ties were less stigmatizing than larger social forces, such as friend groups or neighbors. This is similar to the work of Alegria (2011) and Lo and Cheng (2011) whose research stated that negative perceptions of MHD and treatment led to disinclination to get treatment and worse outcomes. Participant 3 cited their peers as a source of stigma from ridicule that made them not want to get treatment even though their partner had recommended they seek and get

treatment. Participant 4 cited the community's judgment as a disincentive but was still able to seek treatment. For participant 4, the community made an impact but this community was socially more distant than participant 3's closer peer group; meaning that the proximity that the social force occupies to the individual may make a larger difference on the overall effects of stigma.

Lo and Cheng (2011) discussed how these negative perceptions combined with insufficient care ultimately led individuals to face greater challenges and higher rates of morbidity. One participant's experiences of not having access to treatment and their continued cycle of substance use in this study showed the ongoing consequences of non-treatment. This situation is further explained by the stigma this participant's peer group cast upon him and the course of action available to him within these circumstances. Another study finding that not having insurance and concerns over the cost, as well as mistrust in psychiatric treatment were considered as major factors in never accessing treatment was also consistent with Lo and Cheng's (2011) study findings.

Self-medication

The next theme of focus was the role of self-medication through substance use. This study found that all participants utilized substances to quell unpleasant MHD symptoms. Participants in the study reported using substances to ease their unpleasant symptoms and better manage their social environments through altered states of consciousness. This finding was supported by Owens' study (2014) that found individuals with PTSD used substances as a method of

counteracting their PTSD symptoms. Similarly, Following the trend of Owens (2014), participant psycho-social functioning was also interrupted. This disruption was evident within the lack of scholastic engagement. Additionally, two schizophrenia spectrum participants faced psycho-social impairments in the form of homelessness and isolating behaviors.

This study found that some participants cited the need to develop a sense of self-understanding and recognizing triggers for substance seeking behaviors. These actions fall in line with CBT techniques of re-conceptualizing ideas and developing alternative behaviors that benefit individual's dysphoric symptoms. This finding is significant in showing that individuals who have not had access to treatment may still be able to do the type of self-work necessary to improve their conditions. Wolitzky-Taylor et al.'s (2018) study explored the capacity for individuals to reduce their alcohol dependence through the use of cognitive behavioral therapy (CBT). This intervention trend was seen even with two participants who did not receive treatment but still managed to initiate the behavioral changes needed to address their substance dependence.

Identification and Prevention

The following major theme is identification of a DD and how this plays a role in prevention of ultimately becoming Dually Diagnosed. This study found that the majority of the participants (60%) that received treatment within clinical settings were given appropriate diagnoses that guided their treatments. Those individuals' treatment plans were ongoing and well maintained. Though histories

were varied, and different clinical settings were utilized across time, participants were able to benefit from clear diagnoses that dictated the proper course of treatment. Minkoff's (2019) study discussed the importance of clients being properly diagnosed in clinical settings in order to get appropriate care that specifically stops cyclic patterns of dysregulation from SUD/DD. These participants' success coincides with Minkoff's (2019) assertion that, although sometimes complicated, proper diagnosing of applicable MHD and SUD is crucial. On the contrary, participants that did not engage in treatment were unaware of their DD status. This meant that these participants saw their MHD as separate from their SUD. This led to an inability to consider how one diagnosis may impact the other and ultimately stall any actions to address a DD.

Similarly to Mericle et al. (2012), most participants in the study noted experiencing MHD before SUD. In these instances, participants reported the initiation of substances shortly after experiencing MHD or as a method of coping with their MHD. This is indicative of an important point for individuals to begin treatment in order to reduce DD severity in the future. Mericle et al. (2012) went on to state that due to this prevalence of DD, individuals face psycho-social barriers to employment, housing and the like. Participants within this study reported an income but did not specify what type of income it was. The participants' psycho-social barriers were centered on community settings, homelessness and navigating social spaces through skill building.

Structural Considerations

The next theme of focus is the structural intersections to treatment. A half of the participants in this study discussed the way that some structural factors such as being uninsured, being incarcerated, having transportation difficulties, and having job scheduling difficulties contributed to their inability to seek treatment. This finding is consistent with Brown et al.'s study findings (2011) that discussed the structural implications, such as legal obligations, job schedule constraints, transportation, poor self-care, and poor self-management further complicated access to treatment for DDs. Addressing these types of structural barriers is an important step in managing a DD and lessening severity of DD symptoms. These structural factors further complicate individual participation in treatment, being that seeking treatment may already be a difficult task to initiate for individuals facing stigma or mistrust. In contrast to this, one participant who faced homelessness was able to go against the trend and reached out to services through hospital urgent cares and similar programs in efforts to find shelter in addition to treatment. This may be an incentive for some of the population to seek treatment.

Wu and Hser (2011) indicated that substance treatment centers only had about 50% of staff certified to treat substance use and of about 25% of staff having a master's degree or higher to address substance treatment needs. The participants who were involved in treatment in this study discussed the use of treatment teams having a medical doctor, therapist, and psychiatrist (if applicable

to individual needs) or utilizing outpatient services with an established therapist. Although this is a small sample of participants, the quality of services seemed adequate for treatment. This is a great benefit in terms of structural resources available to the participants. Improvements such as these are essential to provide better standards of care to individuals, especially those with concurrent diagnoses.

Support as Empowerment

Finally, the socio-cultural approach that Alegria et al. (2011) proposes is essential to this research study in order to understand the ways that individuals interface with treatment and their societies. For this study, the model has been applied in order to focus on the individual, their capabilities, and how those capabilities intersect within their community's social forces, with some context from the upper levels such as provider factors and federal/state policies and regulations. This is done in order to emphasize the power that individuals hold within their immediate settings and how these can transcend into larger mechanisms, through social workers' mobilization. By harnessing natural supports in a method that reintegrates individuals into their communities and with their families, individuals will be able to take initial steps in creating lasting change. This is seen in the way that participants utilized their familial supports as motivations and catalysts for treatment and personal development to ultimately manage their DD symptomologies.

Limitations

Limitations to this study are the small sample size of 5 participants who were all Latinx. No participants were identified as Black/ African American. Due to this the results of this study may not be applicable to the larger population. This study was conducted during the emergence of COVID-19, which further complicated research advertisement and participation, as all protocols were adapted to non-face to face communications such as Zoom or telephone calls. Another limitation may have been privacy and confidentiality concerns given the sensitivity and stigma surrounding the topic. Additionally, individuals may not have been aware of having a dual diagnosis, thereby thinking they would not be applicable for participation. Another consideration is that the qualifications for meeting a dual diagnosis may be too broad due to the researcher's inability to formally diagnose individuals as a Master of Social Work student.

Recommendations for Practice, Policy, and Research

Given that most individuals in this study had MHD symptoms before initialing substance use and they stated the MHD as the reason or a link to beginning to use substances, it is highly recommended that micro-leveled social workers proactively assess for substance use for adolescents. This means that micro-leveled social workers must understand the intricacies of concurrent MHD and SUD, even before such dual diagnoses become apparent. Mimicking the way that risk assessments are preformed may be a good initial response to start assessing for substance use, with a special emphasis on concurrent MHDs.

Educating and/or providing social workers and social work students trainings on the intricacies of concurrent diagnoses would also be an important step for early detection and prevention of DD. This focus can be applied within university settings as an educational requirement that designates a set period of time to study. Social workers can also seek to develop new specialized treatment interventions for DD.

Within community settings, social workers can work to eliminate the stigma on MHDs while simultaneously increasing awareness on the prevalence of SUDs. By stressing the complexity of a DD, social workers can educate the general population on how MHDs and SUDs can co-occur and what this DD means for quality of life. Once the general population is more aware of DDs, individuals may feel more comfortable in seeking treatment.

On a policy (macro) level, social workers should seek to expand access to medical coverage for all individuals as a human right. These efforts would complement micro leveled approaches previously stated as more advanced preventative interventions. If all individuals have the options for treatment through medical insurance coverage presented to them to access treatment, some of the structural barriers that participants discussed would be alleviated. This would also enhance the overall wellbeing and health of individuals, which strongly impact mental well-being.

Overall further research should be conducted with larger samples to get a better understanding of areas of improvement for treatment access. This

research would also aid in enabling social workers to better understand what it means to work with and treat dual diagnoses properly. Research could also help to guide the creation of a new intervention approach. A specific area of focus for the research to expand upon would be the specific policies that have shaped the health care system in respect to accessing specialized treatments. Findings here could provide insights for politicians and macro leveled social workers to create beneficial legislation for individuals with dual diagnoses.

Conclusion

This chapter covered the role of stigma in treatment, the role of self-medication and how that may hinder individuals' wellbeing, the importance of identification and prevention of DD, structural implications for treatment access, and the role of social supports. Limitations were discussed and recommendations for social workers in micro, macro and academic arenas were proposed.

APPENDIX A
DEMOGRAPHIC SURVEY

- 1) Race/Ethnicity:
Raza / Etnicidad:
- 2) Gender identity:
Identidad de género:
- 3) Age/ Edad: ____ 18-25; ____ 26-33; ____ 34-41; ____ 42-49; ____ 50+
- 4) Educational level:
Nivel educacional:
- 5) Geographical area:
Zona geográfica
- 6) Medical insurance:
Seguro médico
- 7) Annual income range:
Ingresos anuales:
- 8) Diagnosis of substance disorder and mental health disorder:
Diagnóstico de trastorno por sustancias y trastorno de salud mental:

Developed by Pedro Bañuelos

APPENDIX B
INTERVIEW GUIDE

- 1) What was your first instance of a SUD/MHD? Around what age did it start?
What life events were happening during that time?:

¿Cuál fue su primera instancia de un SUD / MHD? ¿Alrededor de qué edad empezó? ¿Qué eventos de la vida sucedieron durante ese tiempo ?:
- 2) Have you ever thought about a connection between SUD and MH? Have you ever thought they might be related?

¿Ha pensado alguna vez en una conexión entre SUD y MH? ¿Alguna vez pensaste que podrían estar relacionados?
- 3) What would you think/feel about seeking treatment for Dual Diagnosis (of substance use disorder/mental health disorders)?

¿Qué pensaría / sentiría acerca de buscar tratamiento para el diagnóstico dual (de trastorno por uso de sustancias / trastornos de salud mental)?
- 4) Have you ever received treatment before? What was your experience like?

¿Ha recibido tratamiento antes? ¿Cómo fue tu experiencia?
- 5) What things would stop you from looking for treatment? What would make you want to look for treatment?

¿Qué cosas le impedirían buscar tratamiento? ¿Qué te haría querer buscar tratamiento?
- 6) How have you managed or gone about dealing with DD so far? How has that felt? What kind of emotions or body sensations have you felt specifically?

¿Cómo ha manejado o ha hecho frente al diagnóstico dual hasta ahora?
¿Cómo se ha sentido eso? ¿Qué tipo de emociones o sensaciones corporales has sentido específicamente?
- 7) What are your family's feelings or thoughts towards seeking treatment?

¿Cuáles son los sentimientos o pensamientos de su familia hacia la búsqueda de tratamiento?

8) What would your culture or community think if you sought out treatment for dual diagnoses?

¿Qué pensaría su cultura o comunidad si buscara tratamiento para el diagnóstico dual?

9) Has your family supported or helping you manage a dual diagnosis?

¿Su familia lo ha apoyado o ayudado a manejar un diagnóstico dual?

Developed by Pedro Bañuelos

APPENDIX C
INFORMED CONSENT

INFORMED CONSENT

The study that you are invited to participate in is designed to explore factors that affect participation in seeking and accessing treatment for dual diagnosed substance use disorders (SUDs) and mental health disorders (MHDs) of the Black and Latino populations within the Inland Empire of Southern California. This study is being conducted by Pedro Bañuelos, a graduate student, under the supervision of Dr. Janet Chang, Professor in the School of Social Work at California State University, San Bernardino (CSUSB). This study has been approved by the Institutional Review Board at CSUSB.

PURPOSE: The purpose of this study is to understand the seeking and access of treatment for dual diagnosed SUDs and MHDs among Black and Latino populations.

DESCRIPTION: Participants will be interviewed on their experiences in seeking and accessing treatment, thoughts on treatment approaches, barriers to treatments, supports for treatment, thoughts on ways to make treatment sound like better alternative.

PARTICIPATION: Your participation in this study is completely voluntary and you may refuse or discontinue your participation at any time without any consequences.

CONFIDENTIALITY: Your responses will be confidential, and data will be reported by population observations.

DURATION: The interview will be 45 minutes to 1 hour in length.

RISKS: No risks are anticipated but certain individuals may feel complex emotions from talking about such personal topics and experiences. Participants do not have to answer if they do not wish to, may skip a question or end their participation at any time.

BENEFITS: No direct benefits are expected for participants. Participants may be able to reflect on their medical care and gain an understanding of barriers. Study findings will help to develop a better understanding of this area of research.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Janet Chang at (909) 537-5184.

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks database (<http://scholarworks.lib.csusb.edu/>) at California State University, San Bernardino after July 2021.

I agree to have this interview be audio recorded: _____ YES _____ NO

I understand that I must be 18 years of age or older to participate in your study, have read and understand the

consent document and agree to participate in your study.

Place an X mark here

Date

CONSENTIMIENTO INFORMADO

El estudio en el que está invitado a participar está diseñado para explorar los factores que afectan la participación en la búsqueda y el acceso al tratamiento para los trastornos por uso de sustancias (TUS) y los trastornos de salud mental (MHD) de diagnóstico dual de las poblaciones negras y latinas dentro del Inland Empire of Southern California. Este estudio está siendo realizado por Pedro Bañuelos, un estudiante de posgrado, bajo la supervisión de la Dra. Janet Chang, Profesora de la Escuela de Trabajo Social de la Universidad Estatal de California, San Bernardino (CSUSB). Este estudio ha sido aprobado por la Junta de Revisión Institucional de CSUSB.

Propósito: El propósito de este estudio es comprender la búsqueda y el acceso al tratamiento para los TUS y MHD de diagnóstico dual entre las poblaciones negras y latinas.

Descripción: Se entrevistará a los participantes sobre sus experiencias en la búsqueda y acceso al tratamiento, pensamientos sobre enfoques de tratamiento, barreras a los tratamientos, apoyos para el tratamiento, y pensamientos sobre formas de hacer que el tratamiento parezca una mejor alternativa.

Participación: Su participación en este estudio es completamente voluntaria y puede rechazar o interrumpir su participación en cualquier momento sin consecuencias.

Confidencialidad: Sus respuestas serán confidenciales y los datos del estudio se informarán mediante observaciones de la población.

Duración: La entrevista tendrá una duración de 45 minutos a 1 hora.

Riesgos: No se anticipan riesgos, pero ciertas personas pueden sentir emociones complejas al hablar sobre temas y experiencias tan personales. Los participantes no tienen que responder si no lo desean, pueden saltarse una pregunta o finalizar su participación en cualquier momento.

Beneficios: No se esperan beneficios directos para los participantes. Los participantes pueden reflexionar sobre su atención médica y comprender las barreras. Los resultados del estudio ayudarán a desarrollar una mejor comprensión de esta área de investigación.

Contacto: Si tiene alguna pregunta sobre este estudio, comuníquese con la Dra. Janet Chang al (909)537-5184.

Resultados: Los resultados del estudio se pueden obtener de la base de datos ScholarWorks de la biblioteca de Pfau. (<http://scholarworks.lib.csusb.edu/>) en la Universidad Estatal de California, San Bernardino después de julio de 2021.

Acepto que esta entrevista se grabe en audio: _____ Si _____ No

Entiendo que debo tener 18 años o más para participar en su estudio, haber leído y comprendido el documento de consentimiento y acepta participar en su estudio.

Coloque una marca X aquí

Fecha

APPENDIX D
RESEARCH FLIER

RESEARCH PROJECT SEEKING PARTICIPANTS

Study focus on Mental
Health Disorders and
Substance Use within
Black / African American
and Latino individuals

Participant information kept confidential

\$10 gift card for participation

*Online Video or Phone Interviews:
45mins - 1 hr*

*This study has been approved by the California
State University, San Bernardino Institutional Review Board*



Researcher contact info (ask for Pedro)

E-mail:

007065663@coyote.csusb.edu



Call (951)435-1723

For any concerns, reach out to research supervisor:

jchang@csusb.edu

APPENDIX E
DEBRIEFING STATEMENT

This study you have just completed was designed to learn more about accessing care for dual diagnosed individuals. By participating you may have discussed difficult topics to process, so the researcher would like to offer local services that may be useful. Please reach out to these if needed:

Este estudio que acaba de completar fue diseñado para obtener más información sobre el acceso a la atención para personas con diagnóstico dual. Al participar, es posible que haya hablado sobre temas difíciles de procesar, por lo que al investigador le gustaría ofrecer servicios locales que pueden ser útiles. Comuníquese con estos si es necesario:

San Bernardino County/ Condado de San Bernardino

Crisis Stabilization/ Estabilización de crisis

- Windsor Center
Crisis Stabilization Unit – A, ADS, C, F, MH, P
([view legend](#))
1481 N. Windsor Drive
San Bernardino, CA
Ph: (909) 361-6470 or 7-1-1 for TTY Users
Hours of Operation: 24 hours a day, 7 days a week/ Horas de operación: 24 horas al día, 7 días a la semana
- Merrill Center
Crisis Stabilization Unit – A, ADS, C, F, MH, P
([view legend](#))
14677 Merrill Ave
Fontana, CA
Ph: (951) 643-2340 or 7-1-1 for TTY Users
Hours of Operation: 24 hours a day, 7 days a week/ Horas de operación: 24 horas al día, 7 días a la semana

Recovery Based Engagement Support Team (RBEST) provides community outreach, engagement, case management, family education, support, and therapy
(909) 421-9452

El equipo de apoyo a la participación basada en la recuperación (RBEST) proporciona alcance comunitario, participación, gestión de casos, educación familiar, apoyo y terapia (909) 421-9452

Detox Services

Servicios de desintoxicación

- Cedar House Life Change Center
18612 Santa Ana Ave.

Bloomington, CA 92316
Phone: (909) 421-7120

- Inland Valley Recovery Services
Upland Recovery Center
1260 Arrow Highway
Bldg. C
Upland, CA 91786
Phone: (909) 932-1069

Recovery centers – classes and sober living support

Centros de recuperación: clases y apoyo para una vida sobria

- Inland Valley Recovery Services
San Bernardino Recovery Center
939 North D Street
San Bernardino, CA 92410
Phone: (909) 889-6519
- Inland Valley Recovery Services
Upland Recovery Center
934 N. Mountain Ave.
Suites A & B
Upland, CA 91786
Phone: (909) 949-4667
- MHS Central Valley Regional Recovery Center
1076 Santo Antonio Drive
Suite B
Colton, CA 92324
Phone: (909) 433-9824
- St. John of God
Hospitality Center
15534 6th Street
Victorville, CA 92393
Phone: (760) 952-9192

Riverside County/ Condado de Riverside

Crisis Stabilization/ Estabilización de crisis

- 9990 County Farm Road, Ste. 4
Riverside, CA 92503

Phone: (951) 358-4881
Se Habla Español

- **85 Ramona Expressway, Suites 1-3**
Perris, CA 92571
951-349-4195 Main
- **Blaine Street Adult Clinic**
[769 Blaine Street, Suite B Riverside, CA 92507](#)
Phone: (951) 358-4705
Fax: (951) 358-4719
- **Hemet Mental Health Clinic**
[650 North State Street](#)
[Hemet, CA 92543](#)
Phone: (951) 791-3300

Substance Use Community Access, Referral, Evaluation, and Support (SU CARES)
Line: (800) 499-3008

Línea de acceso, derivación, evaluación y apoyo de la comunidad para el uso de sustancias (SU CARES): (800) 499-3008

APPENDIX F
INSTITUTIONAL REVIEW BOARD APPROVAL



Pedro Bañuelos <007065663@coyote.csusb.edu>

IRB-FY2021-85 - Initial: IRB Expedited Review Approval Letter

2 messages

IRB@csusb.edu <IRB@csusb.edu>

Tue, Dec 22, 2020 at 6:46 PM

To: 007065663@coyote.csusb.edu, JChang@csusb.edu



December 22, 2020

CSUSB INSTITUTIONAL REVIEW BOARD

Expedited Review

IRB-FY2021-85

Status: Approved

Janet ChangPedro Bañuelos
 CSBS - Social Work
 California State University, San Bernardino
 5500 University Parkway
 San Bernardino, California 92407

Dear Janet ChangPedro Bañuelos:

Your application to use human subjects, titled "Treatment access for dual diagnosis substance use and mental health disorder within Black and Latino populations" has been reviewed and reviewed and approved by the Institutional Review Board (IRB) of CSU, San Bernardino. The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk and benefits of the study except to ensure the protection of human participants. Important Note: This approval notice does not replace any departmental or additional campus approvals which may be required including access to CSUSB campus facilities and affiliate campuses due to the COVID-19 pandemic. Visit the Office of Academic Research website for more information at <https://www.csusb.edu/academic-research>.

The study is approved as of December 22, 2020. The study will require an annual administrative check-in (annual report) on the current status of the study on --. Please use the renewal form to complete the annual report.

If your study is closed to enrollment, the data has been de-identified, and you're only analyzing the data - you may close the study by submitting the Closure Application Form through the Cayuse IRB system. Please note the Cayuse IRB system will notify you when your protocol is due for renewal. Ensure you file your protocol renewal and continuing review form through the Cayuse IRB system to keep your protocol current and active unless you have completed your study. Please note a lapse in your approval may result in your not being able to use the data collected during the lapse in your approval.

You are required to notify the IRB of the following as mandated by the Office of Human Research Protections (OHRP) federal regulations 45 CFR 46 and CSUSB IRB policy. The forms (modification, renewal, unanticipated/adverse event, study closure) are located in the Cayuse IRB System with instructions provided on the IRB Applications, Forms, and Submission Webpage. Failure to notify the IRB of the following requirements may result in disciplinary action.

- Ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.
- Submit a protocol modification (change) if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before being implementing in your study.
- Notify the IRB within 5 days of any unanticipated or adverse events experienced by subjects during your research.

<https://mail.google.com/mail/u/1/?ik=40129d7a21&view=pt&search=all&permthid=thread-f%3A1686835363909550819&siml=msq-f%3A16868353639...> 1/2

- Submit a study closure through the Cayuse IRB submission system once your study has ended.

The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risks and benefits to the human participants in your IRB application. If you have any questions about the IRBs decision please contact Michael Gillespie, the IRB Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillespie@csusb.edu. Please include your application approval number IRB-FY2021-85 in all correspondence. Any complaints you receive regarding your research from participants or others should be directed to Mr. Gillespie.

Best of luck with your research.

Sincerely,

Nicole Dabbs

Nicole Dabbs, Ph.D., IRB Chair
 CSUSB Institutional Review Board

ND/MG



Pedro Bañuelos <007065663@coyote.csusb.edu>

IRB-FY2021-85 - Modification: IRB Approval Protocol Change/Modification Letter

1 message

IRB@csusb.edu <IRB@csusb.edu>

Fri, Jan 8, 2021 at 3:45 PM

To: 007065663@coyote.csusb.edu, JChang@csusb.edu



January 8, 2021

CSUSB INSTITUTIONAL REVIEW BOARD

Protocol Change/Modification

IRB-FY2021-85

Status: Approved

Janet ChangPedro Bañuelos
 CSBS - Social Work
 California State University, San Bernardino
 5500 University Parkway
 San Bernardino, California 92407

Dear Janet Chang Pedro Bañuelos:

The protocol change/modification to your application to use human subjects, titled "Treatment access for dual diagnosis substance use and mental health disorder within Black and Latino populations" has been reviewed and approved by the Chair of the Institutional Review Board (IRB). A change in your informed consent requires resubmission of your protocol as amended. Please ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study. A lapse in your approval may result in your not being able to use the data collected during the lapse in your approval.

This approval notice does not replace any departmental or additional campus approvals which may be required including access to CSUSB campus facilities and affiliate campuses due to the COVID-19 pandemic. Visit the Office of Academic Research website for more information at <https://www.csusb.edu/academic-research>.

You are required to notify the IRB of the following by submitting the appropriate form (modification, unanticipated/adverse event, renewal, study closure) through the online Cayuse IRB Submission System.

1. If you need to make any changes/modifications to your protocol submit a modification form as the IRB must review all changes before implementing in your study to ensure the degree of risk has not changed.
2. If any unanticipated adverse events are experienced by subjects during your research study or project.
3. If your study has not been completed submit a renewal to the IRB.
4. If you are no longer conducting the study or project submit a study closure.

You are required to keep copies of the informed consent forms and data for at least three years.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, Research Compliance Officer. Mr. Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval number IRB-FY2021-85 in all correspondence.

Best of luck with your research.

<https://mail.google.com/mail/u/1?ik=40129d7a21&view=pt&search=all&permthid=thread-f%3A1688364161811949661&simpl=msg-f%3A1688364161811949661> 1/2

Sincerely,

Nicole Dabbs

Nicole Dabbs, Ph.D. IRB Chair
 CSUSB Institutional Review Board

ND/MG

REFERENCES

- Alegria, M., Carson, N. J., Goncalves, M., & Keefe, K. (2011). Disparities in treatment for substance use disorders and co-occurring disorders for ethnic/racial minority youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, 50(1), 22-31.
- Brown, C. H., Bennett, M. E., Li, L., & Bellack, A. S. (2011). Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors*, 36(5), 439–447. <https://doi-org.libproxy.lib.csusb.edu/10.1016/j.addbeh.2010.12.001>
- Carver, H., Ring, N., Miler, J., & Parkes, T. (2020). What constitutes effective problematic substance use treatment from the perspective of people who are homeless? A systematic review and meta-ethnography. *Harm Reduction Journal*, 17(1), 1-22. <https://doi.org/10.1186/s12954-020-0356-9>
- Jaffe, A., Du, J., Huang, D., & Hser, Y.-I. (2012). Drug-abusing offenders with comorbid mental disorders: Problem severity, treatment participation, and recidivism. *Journal of Substance Abuse Treatment*, 43(2), 244–250. <https://doi-org.libproxy.lib.csusb.edu/10.1016/j.jsat.2011.12.002>
- Lo, C. C., & Cheng, T. C. (2011). Racial/ethnic differences in access to substance abuse treatment. *Journal of Health Care for the Poor and Underserved*, 22(2), 621-637.

- McGovern, M. P., Lambert-Harris, C., Gotham, H. J., Claus, R. E., & Xie, H. (2014). Dual diagnosis capability in mental health and addiction treatment services: an assessment of programs across multiple state systems. *Administration and Policy in Mental Health and Mental Health Services Research, 41*(2), 205-214.
- Mericle, A. A., Ta Park, V. M, Holck, P., & Arria, A. M. (2012). Prevalence, patterns, and correlates of co-occurring substance use and mental disorders in the United States: Variations by race/ethnicity. *Comprehensive Psychiatry, 53*(6), 657-665.
- Minkoff, K. (2019). Substance Use Disorders in crisis settings: Engagement, assessment, and intervention approaches. *Psychiatric Times, 36*(1), 26–29.
- Nordeck, C., Welsh, C., Schwartz, R., Mitchell, S., Cohen, A., O'Grady, K., & Gryczynski, J. (2018). Rehospitalization and substance use disorder (SUD) treatment entry among patients seen by a hospital SUD consultation-liaison service. *Drug and Alcohol Dependence, 186*, 23-28.
- Owens, G., Held, P., Blackburn, L., Auerbach, J., Clark, A., Herrera, Cook, J., & Stuart, G. (2014). Differences in relationship conflict, attachment, and depression in treatment-seeking veterans with hazardous substance use, PTSD, or PTSD and hazardous substance use. *Journal of Interpersonal Violence, 29*(7), 1318-1337.
- Perron, B. E., Bunger, A., Bender, K., Vaughn, M. G., & Howard, M. O. (2010). Treatment guidelines for substance use disorders and serious mental

illnesses: do they address co-occurring disorders?. *Substance use & misuse*, 45(7-8), 1262-1278.

Robbins, M. S., Feaster, D. J., Horigian, V. E., Rohrbaugh, M., Shoham, V., Bachrach, K., ... & Vandermark, N. (2011). Brief strategic family therapy versus treatment as usual: Results of a multisite randomized trial for substance using adolescents. *Journal of consulting and clinical psychology*, 79(6), 713.

Substance Abuse and Mental Health Services Administration. (2018a). 2018 *National survey on drug use and health: African Americans*.
https://www.samhsa.gov/data/sites/default/files/reports/rpt23247/2_African_American_2020_01_14_508.pdf

Substance Abuse and Mental Health Services Administration. (2018b). 2018 *National survey on drug use and health: Hispanics, Latino or Spanish origin or descent*.
https://www.samhsa.gov/data/sites/default/files/reports/rpt23249/4_Hispanic_2020_01_14_508.pdf

Wolitzky-Taylor, K., Drazdowski, Niles, Roy-Byrne, Ries, Rawson, & Craske. (2018). Change in anxiety sensitivity and substance use coping motives as putative mediators of treatment efficacy among substance users. *Behaviour Research and Therapy*, 107, 34-41.

Wu, F., & Hser, Y.-I. (2011). Workforce professionalism in drug treatment services: Impact of California's proposition 36. *Journal of Substance*

Abuse Treatment, 40(1), 44–55. <https://doi->

[org.libproxy.lib.csusb.edu/10.1016/j.jsat.2010.08.006](https://doi-org.libproxy.lib.csusb.edu/10.1016/j.jsat.2010.08.006)

Zastrow, C. H., & Kirst-Ashman, K. K. (2016, 2019). Understanding human behavior and the social environment. Boston, MA: Cengage Learning.